Making sense of youth suicide: Exploring young New Zealanders' views

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Abstract

Due to its sensitive nature, the suicide of young people can be a complex and difficult issue to address; yet it needs to be better understood in order to reduce the rate of young New Zealanders who die from suicide. While there has been a significant amount of research conducted on youth suicide, the aim of this research was to gain a deeper understanding of youth suicide within New Zealand by exploring why young people think their peers attempt, or die from, suicide. Six focus groups were held with 19 participants aged 16 to 24 years old. Discussions were transcribed and thematic analysis of the transcripts identified five themes and ten subthemes. These were: relationship factors (bullying and intimate relationships), internal factors (depressive disorders and coping skills), gender (kiwi masculinity and rates), external factors (alcohol and other drugs and circumstances), and support services (access and reluctance/barriers). The participants identified that youth suicide can be the result of a variety of factors, particularly noting the relationship between bullying (face to face or cyber-bullying) and suicide. It is recommended that a component which addresses youth suicide and provides young people with positive coping strategies is implemented into the New Zealand educational curriculum. It is anticipated that changes to the education curriculum, and by society challenging and changing common gender stereotypes, will help reduce youth suicide within New Zealand. Given that this research utilised a small sample size, where the majority of participants were female of European or Pakeha descent, future research with a larger more diverse sample would be beneficial.

Acknowledgements

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To the 19 individuals who volunteered to participate in my research, thank you for sharing your valuable views on youth suicide within New Zealand.

Lastly, to my husband Kieran and our three sons, Eli, Finn, and Zach, who sacrificed family time while I completed this research, thank you.

Dedication

My first experience with suicide was when I was 10 years old, when my uncle died from suicide. During the process of this research a childhood friend died from suicide. This research is dedicated to Richard and Tracey, and to the many other young New Zealanders who have died too early.

Richard John Sollitt

16th July 1968 - 19th September 1993

Tracey Ann Webster

16th March 1984 - 1st June 2016

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Foreword

The New Zealand Crimes Act (1908) contained two provisions relating to the criminalisation of suicide. Section 192: aiding and abetting suicide stated "everyone is liable to imprisonment with hard labour for life who counsels or procures any person to commit suicide, if such person actually commits suicide as a consequence of such counselling or procurement, or who aids or abets any person in the commission of suicide" (Crimes, 1908, p. 605). Section 193: attempt to commit suicide stated that "everyone who attempts to commit suicide is liable to two years' imprisonment with hard labour" (Crimes, 1908, p. 605). Later amendments resulted in Section 193 being removed. Currently, the Crimes Act (1961) has two provisions relating to suicide; Section 179: aiding and abetting suicide and Section 180: suicide pact (Ministry of Justice, 2015). At this time, New Zealand legislation does not consider a suicide, or an attempt, to be an offense.

Frequently, when an individual dies from suicide it is reported that they 'committed suicide'. At the beginning of this research I used this terminology. Through the process of this research I discovered that this terminology is inappropriate for two reasons. This is due to the fact that the act of suicide is not considered an offense within New Zealand, and as family members and friends who have lost a loved one can find this terminology offensive. Suicide is a manner in which someone has died, and it is important to remember that for every person who dies from suicide there are many others who are affected. For this reason, I have used terminology such as 'died from suicide' throughout this discussion.

Chapter 1

Suicide: Terminology, Prevalence, and Risk Factors

There are always two parties to a death; the person who dies and the survivors who are left behind (Toynbee, 1968, p. 267).

Does talking about suicide increase suicidal tendencies in young people? Dazzi, Gribble, Wessely, and Fear (2014) conducted a literature review to explore the impact of enquiring about suicidal ideation in adolescents and adults. Findings indicated that there was no statistically significant increase in suicidal ideation among participants when they were asked about suicidal thoughts. In addition, Dazzi et al. (2014) report that acknowledging and talking about suicide may in fact reduce, rather than increase, suicidal ideation.

In June 2015 Mike King hosted a New Zealand based documentary on youth suicide. In "Target Zero" King openly discussed his past alcohol and drug use, his struggle with mental health, and his suicide attempts. According to King, young New Zealander's are concerned with being weak, they feel an expectation to hide their emotions, and Māori males believe they need to "harden up" (King, 2015). One young person discussed how she lost five cousins and eight friends to suicide, how she first attempted suicide at the age of 12 years old, and has made a total of five suicide attempts. Another young person attempted suicide at the age of 12 or 13 years old, three years after his Nan died. He "couldn't see a light at the end of the tunnel" (King, 2015), and although he "had plenty of people to talk to" (King, 2015) he did not seek support. In regards to losing a peer to suicide, one young person

stated that “it’s really hard, especially when it’s unexplained, you feel lost, yourself, because you don’t know why they’ve done it” (King, 2015).

This documentary provides information of youth suicide within New Zealand and offers insight into young peoples’ perceptions of suicide. It highlights the frequency of youth suicide and the impact it has on young people. In order to understand youth suicide this chapter will define suicidal behaviour, discuss the prevalence of youth suicide, and outline risk factors.

Definition of Suicide

The World Health Organization (2014) defines suicidal behaviour as “a range of behaviours that include suicide ideation, planning for suicide, attempting suicide and suicide itself” (p. 12). More specifically, the World Health Organization (2014) defines suicide as “the act of deliberately killing oneself” (p. 12). An attempted suicide is defined as “any non-fatal suicidal behaviour”, which includes “intentional self-inflicted poisoning, injury or self-harm which may or may not have a fatal intent or outcome” (World Health Organization, 2014, p. 12). Non-fatal self-harm without suicidal intent is included within the definition of a suicide attempt; the World Health Organization acknowledge the complexity of this, highlighting that it can be difficult to assess suicidal intent due to “ambivalence or concealment” (World Health Organization, 2014).

Prevalence of suicide

In 2012 there were an estimated 804,000 people worldwide who died from suicide; the "global age-standardised rate was 11.4 per 100,000 population (15.0 males and 8.0 females)" (World Health Organization, 2014, p. 10). The World Health Organization (2014) acknowledge the likelihood that suicide is under-reported within some countries, due to its sensitivity, and as suicide is considered illegal in some parts of the world.

Table 1 provides the age-standardised rates for death from suicide within New Zealand. In 2012 the New Zealand age-standardised rate was 12.1 per 100,000 population (18.1 males and 6.4 females), higher than the global age-standardised rate for 2012. Between 2004 and 2013 the age-standardised rate for suicide in New Zealand was between 10.9 and 12.2 per 100,000.

Within New Zealand, males die from suicide at a higher rate than females. This gender difference is possibly best accounted for by the method of suicide, with males and females choosing a different method of lethality (Spirito & Esposito-Smythers, 2006). If females were to adopt a more lethal method for suicide it is likely that the gender difference would reduce (Spirito & Esposito-Smythers, 2006).

The age-standardised rate for suicide by New Zealand Māori in 2012 was 35.8 per 100,000, compared to the non-Māori age-standardised rate of 21.5 per 100,000 (refer to Table 1). It is argued that the higher rate of Māori suicide reflects the disadvantaged status of Māori within New Zealand society (Beautrais & Fergusson, 2006). New Zealand Māori have lower levels of literacy and fewer educational qualifications compared to non-Māori (Chapple, 2000). In addition, Māori have a poorer health status, which Chapple (2000) argues could be caused by a lack of ethnic

Table 1

Suicide within New Zealand

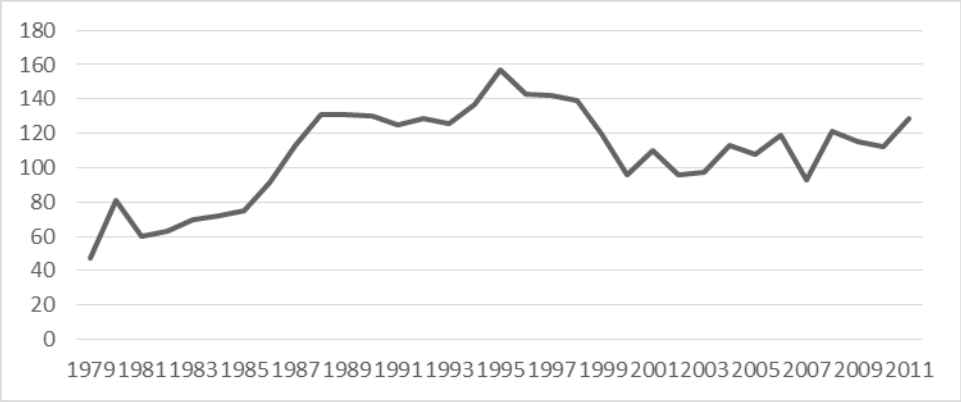
	Year									
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
Suicides										
Male	379	380	388	371	381	393	386	377	404	365
Female	109	131	138	116	139	117	149	116	146	143
Total	488	511	526	487	520	510	535	493	550	508
Age-standardised rate (per 100,000)										
Male	18.6	18.6	18.6	17.4	17.6	17.9	17.3	17.0	18.1	16.0
Female	5.2	6.0	6.3	5.0	6.2	5.0	6.6	5.1	6.4	6.3
Total	11.7	12.2	12.2	11.0	11.8	11.3	11.8	10.9	12.1	11.0
Age-specific rates by life-stage age group (per 100,000)										
15–24	19.3	18.1	19.7	15.2	19.5	18.1	17.7	20.1	23.0	18.0
25–44	17.0	18.5	17.7	17.4	15.6	14.9	16.8	13.9	15.8	14.0
45–64	12.5	14.2	14.1	13.5	15.2	14.8	14.6	13.5	13.1	15.8
65+	10.9	9.6	10.0	9.3	9.5	9.6	10.0	7.7	9.5	8.5
Age-standardised rates for Māori (per 100,000)										
Male	29.0	26.9	25.9	25.9	19.8	19.3	23.9	26.3	25.3	21.1
Female	8.4	8.3	10.7	7.3	8.9	7.4	9.4	9.5	10.5	11.1
Age-standardised rates for non-Māori (per 100,000)										
Male	16.5	16.8	17.0	15.7	17.0	17.4	15.7	14.9	16.3	14.6
Female	4.5	5.4	5.3	4.4	5.4	4.4	5.9	4.0	5.2	5.0

Source: Ministry of Health Mortality Collection

responsiveness in the health system, or barriers to accessing resources. These factors negatively impact on Māori and, as a result, Māori are over-represented amongst poorer social classes (Chapple, 2000). Alternatively, the higher rates of Māori suicide may be the result of factors that are unique to Māori and their experience of colonisation (Reid & Robson, 2000). Regardless of the influencing variables, the rate of suicide by Māori is disproportionately higher than the rate of suicide by non-Māori.

Worldwide, suicide is the second leading cause of death for people aged 15 to 29 years old (after motor vehicle accidents), and accounts for 8.5% of deaths within this age range (World Health Organization, 2014). The 2012 age-standardised rate for New Zealanders aged 15 to 24 years old was 23.0 per 100,000 population, which ranged from 15.2 to 23.0 over the period of 2004 to 2013 (refer to Table 1). In addition, the number of New Zealanders aged 15 to 24 years old, who have died from suicide, has remained fairly stable over the last four decades (refer to Figure 1).

Figure 1



Number of deaths from suicide for males and females aged 15-24 years old New Zealand

Source: World Health Organization 2014

To provide context for the number of deaths, the most recent statistics, for the period from July 2014 to June 2015, record 113 New Zealanders, 79 males and 34 females, aged between 15 to 24 years old, who died from suicide (Annual, 2015). Based on these figures, one New Zealander aged 15 to 24 years old dies from suicide every three days.

In addition, it is necessary to consider suicide attempts. As this data is not explicitly recorded within New Zealand it is useful to examine the rates of hospitalisation due to intentional self-harm, as this could be a suicide attempt. During 2012, throughout New Zealand, there were a total of 1052 young people aged 15 to 24 years old who were hospitalised as the result of intentional self-harm (Ministry of Health, 2012). Of these individuals the majority were female (69%) and 10% identified as Māori (Ministry of Health, 2012). While it is unclear what level of intentional self-harm these young people experienced, it is possible that a proportion of these young people had attempted suicide.

Overall, these statistics demonstrate that young people living within New Zealand are dying from suicide at alarmingly high rates. In 2011, Judge Neil MacLean, the New Zealand Chief Coroner, stated that current methods for suicide prevention are ineffective and stressed that a new approach is required in order to reduce the number of deaths from suicide (3 News, 2011). For this to occur more insight into youth suicide within New Zealand is necessary. It is useful to explore common risk factors, which are outlined below.

Risk Factors

The period of adolescence and young adulthood is a complex developmental stage, with many socio-cultural factors that influence decisions. It is imperative to

consider which factors place a young person at risk of suicide. Research has identified many risk factors associated with youth suicide and suicide attempts. Following is a discussion of commonly cited risk factors, including previous suicide attempts, psychopathology, anxiety, family relationships, sexuality, adverse life events, and bullying.

Previous Suicide Attempt

A previous suicide attempt is one of the best predictors of future suicide attempts (Lewinsohn, Rohde, & Seeley, 1994) and suicide (Shaffer et al., 1996). Estimates are that between one quarter and one third of young people who die from suicide have made a prior suicide attempt (Groholt, Ekeberg, Wichstorm, & Haldorsen, 1997). The risk is particularly high for males (with a 30 fold increase), and is less elevated for females (with a three-fold increase) (Shaffer et al., 1996). It is possible that a prior suicide attempt sensitises an individual to suicide related thoughts and behaviours (Beck, 1996). As a result of this, an individual may be more likely to view suicide as a viable solution and consider it in the future.

Psychopathology

Psychiatric disorders are an established risk factor for suicide in young people, and found to be present in over 90% of young people who have died from suicide (Brent et al., 1993). Depressive disorders are consistently reported as the most prevalent psychopathology amongst young people who die from suicide, ranging from 49% to 64% (Brent et al., 1993). Blau (1996) stated that suicide is the result of the negative feelings of hopelessness, which are often associated with depressive disorders,

rather than an individual who has an explicit wish to die. Within New Zealand, the Ministry of Health considers depressive disorders the most common psychopathology associated with suicidal behaviour (Curtis & Curtis, 2011). In 2006 Jim Anderton, the New Zealand Associate Minister for Health, stated that "we know that up to 90% of suicides are *caused* by depression and that each year 500 New Zealanders are dying by suicide" (emphasis added) (Anderton, 2006). Fisher (1999) reviewed seven psychological autopsies of completed suicide and found rates of major depression ranged from 23-52%, and that depressive disorders were not present in all suicides. Therefore, the comment by Anderton (2006) incorrectly states, to the New Zealand public, that there is a causal relationship between depressive disorders and suicide.

Research has identified a strong relationship between substance use disorders and suicide within young people. Based in the United States of America, Shaffer et al. (1996) conducted a case-control psychological autopsy; there were 120 individuals under the age of 20 years who had died from suicide, and an age, gender, and race matched community control sample of 147 young people. Within the sample of those who died from suicide, 35% met the criteria for a substance use disorder, 22% met the criteria for alcohol abuse, and 25% of the sample had illicit drug use. The presence of any substance abuse disorder was six times greater among males who died from suicide, in comparison with the matched community controls. In addition, young people who had a co-morbid substance use and mood disorder were found to be at significantly greater risk of suicide, when compared to young people who had a substance abuse but not a mood disorder (Brent et al., 1993). This research identified a correlational relationship between substance use disorders and suicide. It is important to consider the context for how young people develop a substance use disorder; and for health

promotion to target these factors with the aim of reducing substance use disorders and suicide.

While there is evidence of a relationship between psychopathology and suicide this does not demonstrate causality, as not all individuals with a psychopathology die from suicide. Shahtahmasebi (2003) found that 66-75% of individuals who died from suicide did not have contact with psychiatric services, and of those who had a psychiatric diagnosis only a small percentage had a diagnosis of a depressive disorder. Therefore, it is necessary to be cautious when making statements that imply causality, and to avoid unnecessarily pathologising individuals. Given this, the focus on suicide being the result of a depressive disorder or any other psychopathology needs to shift as there is no single identified cause of suicide.

Anxiety

In addition, anxiety has been identified as a risk factor for suicide. Anxiety is characterised by a "diffuse, unpleasant, vague sense of apprehension, often accompanied by autonomic symptoms such as headache, perspiration, palpitation, tightness in the chest, mild stomach discomfort, and restlessness, indicated by an inability to sit or stand still for long" (Kaplan, Sadock, & Ruiz, 2015, p. 387). Goldston, Daniel, Reboussin, Kelley, Ievers, and Brunstetter (1996) investigated the relationship between state and trait anxiety and suicide. State anxiety is the fear, nervousness, discomfort, and arousal of the autonomic nervous system which is temporarily induced by situations perceived as dangerous; trait anxiety refers to the disposition to feel stress, worry, and discomfort (Groth-Marnat, 2009). Goldston et al. (1996) found, based on an inpatient sample, the relationship between trait anxiety and

suicide was stronger than the relationship between state anxiety and suicide. Similar to this, Stein, Apter, Ratzoni, Har-Even, and Avidan (1998) compared anxiety of young people: 32 hospitalised after a suicide attempt, 19 hospitalised after their fifth or subsequent suicide attempt, 109 non-suicidal psychiatric inpatients, and 85 community controls. Stein et al. (1998) identified that those who had one suicide attempt reported more trait anxiety than non-suicidal inpatients and community controls. In addition, they identified that both of the suicidal groups reported more state anxiety than the non-suicidal inpatients or community control groups. Therefore, while suicide can be the response to an anxiety provoking situation, individuals who have high levels of trait anxiety are also at risk of suicide.

Family Relationships

High rates of parental psychopathology (especially depressive disorders and substance abuse) are associated with suicide attempts (Fergusson & Lynskey, 1995) and suicide in young people (Gould, Fisher, Parides, Flory, & Shaffer, 1996). In addition, a family history of suicidal behaviour greatly increases the risk of suicide (Agerbo, Nordentoft, & Mortensen, 2002), and suicide attempts (Glowinski et al., 2001). Brent et al. (2002) compared 183 offspring of suicide attempters (24.5% females, mean age = 20.4, *SD* = 12.3) and 116 offspring (41.4% females, mean age = 18.5, *SD* = 10.6) of non-attempters and reported that suicidal behaviour, rather than suicidal ideation, is transmitted within a family. Specifically, individuals with a parent who attempted suicide were six times more likely to attempt suicide, when compared to the offspring of someone who had never attempted suicide (Brent et al., 2002). However, this transmission was found only in mother to child relationships; possibly as the fathers

often did not have access to their children. Based in Denmark, Agerbo et al. (2002) compared 496 young people (77.8% males) aged 10 to 21 years old, who died from suicide between 1981 and 1997, with 24,800 community controls. They reported suicide in young people to be nearly five times more likely in the offspring of mothers who died from suicide, and twice as common in the offspring of fathers who died from suicide, when compared to community controls.

In addition, the home environment has an impact on a young person's risk of suicide. Based in New York, Gould et al. (1996) compared 120 individuals who died from suicide with 147 community controls and found that those who died from suicide had significantly less frequent and less satisfying communication with both their mother and father. Wagner, Silverman, and Martin (2003) found unsatisfying parent-child relationships, with low cohesion and high conflict, were more frequently identified in the families of young people who attempted suicide, when compared with a control sample. The parent-child conflict was more common among younger adolescents (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999). Furthermore, Beautrais (2001) found that those who died from suicide were more likely to come from a home where the parents were separated. Given this, it is important to consider how young people can be supported when their parents have separated, or when the relationships within the home are characterised by conflict.

Sexuality

Based in the United States of America, Russell and Joyner (2001) interviewed 11,940 young people (52.4% females). Using audio computer-aided self-interviews they collected information on sexuality and suicidality. Of the sample, 7% reported same-

sex orientation. Using logistic regression Russell and Joyner (2001) found that those who reported a same-sex orientation were significantly more likely to report suicidality. In addition, they were two times more likely than their same-sex peers to attempt suicide (Russell & Joyner, 2001). Shaffer, Fisher, Hicks, Parides, and Gould (1995) examined the sexual orientation of 120 individuals under the age of 20 years old, who died from suicide (95 males and 25 females) and 147 controls matched by age, sex, and ethnicity, living in New York. Of the males who died from suicide, 3.2% had reported a same-sex experience; none of the male controls, or females who died from suicide reported a same-sex experience. In a review by McDaniel, Purcell, and D'Augelli (2001) it was found that young people who engage in same-sex relationships are at a higher risk of maladaptive coping behaviours, psychiatric disorders, and/or substance abuse disorders, which are pre-disposing factors to suicide. Overall, death from suicide is comparable amongst all young people, regardless of their sexuality (McDaniel et al., 2001). The rates are mediated by depressive disorders, alcohol abuse, a family history of attempts, and victimisation related to their sexuality (Russell & Joyner, 2001). While it is useful to consider the impact of sexuality on suicide it is important to consider that some young people may not be willing to disclose their sexual preferences. Therefore, these results must be considered cautiously.

Adverse life events

Adolescence is a period where many changes occur, and some young people experience adverse life events, which can later be associated with suicide. Evans, Hawton, and Rodham (2005) conducted a systematic review and reported that young people who had been physically or sexually abused were significantly more likely to

report suicidal thoughts or behaviours, when compared to young people who had not been abused. Based in New York, Johnson et al. (2002) found childhood physical abuse to be associated with an increased risk of suicide attempts in later adolescence or early adulthood, even after adjusting for demographic characteristics and psychopathology of the individual and family. In addition, the experience of loss can impact on suicidality. The death of a parent, and early parental loss in general, increase the risk of a young person attempting or completing suicide (Agerbo et al., 2002). Likewise, the interpersonal loss that results from the break up with a romantic partner has been associated with suicide (Beautrais, 2001), though these romantic difficulties are more common in older adolescents (Brent et al., 1999). Furthermore, it has been found that peers of someone who died from suicide have an elevated risk of suicidal ideation, plans, and behaviour, when compared to a control sample (Ho, Leung, Hung, Lee, & Tang, 2000). Specifically, Sinyor, Shaffer, and Cheung (2014) reported that young people exposed to a suicide within their secondary school have a substantially higher risk of suicidal ideation and attempts, regardless of whether or not they knew the student who died.

It is possible that young people have not developed the necessary skills to adequately cope with these situations, and that this influences their contemplation of suicide. McLaughlin, Miller, and Warwick (1996) found that 68% of young people who attempted suicide expected that it would positively influence their problems, by leading to death or temporary relief from their problems, or committing their level of pain to others; 38% reported that they were unable to think of any other way to solve their problems.

Bullying

Bullying is the behaviour that occurs when someone is "exposed, repeatedly and over time, to negative actions on the part of one or more students" (Olweus, 1997, p. 496). Traditionally, bullying occurred in face to face interactions between individuals. However, with the increasing prevalence of technology, bullying now occurs via cell-phone or through social media cites, such as Facebook.

Kaltiala-Heino, Rimpela, Marttunen, Rimpela, and Rantanen, (1999) interviewed Finnish adolescents aged 14 to 16 years old to examine the association between bullying, depression, and severe suicidal ideation. The study was based on a total of 16,410 students (81% of the population from the schools interviewed), and comprised of 93% of students who were at school on that particular day. Results identified that 6% of males and 5% of females within the sample had been bullied on a weekly basis during that current school term. Of the sample, 9% of males and 2% of females reported that they had bullied others at least weekly. Six per-cent of males and 11% of females were identified as being moderately to severely depressed and severe suicidal ideation was reported by 2% of males and 2% of females. The highest risk of severe suicidal ideation was among those who were bullies, followed by those who were both bullied and bullies themselves. While this was a large representative sample, with a high participation rate, it is possible that experiences of being a bully, and being bullied, may be more common among those who were absent (Kaltiala-Heino et al., 1999). It is possible that young people who are bullying peers have other factors that are influencing their behaviour, and that bullying is a maladaptive coping strategy.

In order to examine the association between bullying and suicide Sinyor, Shaffer, and Cheung (2014) looked at suicides of Toronto youth aged 10 to 19 years

old. In the period between 1998 and 2011, based on Coroner's files, there were 94 suicides. Those in the sample had a mean age of 16.8 years and the majority were male (70.2%). The hypothesis was that bullying would be present in a small number of deaths, and that other stressors (such as psychopathology) would be more prevalent. In six deaths (6.4%) an individual had been bullied, where the bullying occurred in person or via the telephone; there were no deaths where cyber bullying was identified. Sinyor et al. (2014) found that the most common stressors before the suicide were: any stressor of mental and/or physical illness (78%), conflict with parents (21.3%), problems with a romantic partner (17.0%), academic problems (10.6%), and criminal and/or legal problems (10.6%). It was concluded that suicide is the result of complex and various biological, psychological, social factors, of which bullying is merely one variable. However, Sinyor et al. (2014) identified the possibility that, for some of the sample, bullying may not have been recorded on the Coroner's files, and thus is a potential limitation to the research. They concluded that: "conveying that bullying alone (or any one other factor) causes suicide at best minimises, and at worst ignores, the other factors that may contribute to death by suicide" (Sinyor et al., 2014, p. 636).

This chapter provided a definition of suicidal behaviour and the global and New Zealand prevalence of youth suicide. In addition, commonly associated risk factors, which provide valuable information on youth suicide, have been discussed. The phenomenon of suicide has been researched using a variety of different methods; the following chapter will focus on the different ways in which suicide has been investigated.

Chapter 2

Approaches to Investigating Suicidal Behaviour

Given the high number of young people who die from suicide there has been a significant amount of research, with the aim of developing an understanding of which factors influence suicide. In the following section, common research methods to investigate suicide, and their findings, are discussed. It is necessary to identify these various methods as each provides diverse information on the contextual factors.

Psychological Autopsy

A psychological autopsy is a commonly utilised research method. During a psychological autopsy, family members take part in semi-structured interviews, with the aim of retrospectively examining the deceased's psychological state at the time of their suicide (Henry & Greenfield, 2009). In addition, psychological autopsies consider all major life circumstances of the deceased prior to their suicide (Henry & Greenfield, 2009) and provide a context at the time of their death.

An example of a psychological autopsy is that by Houston, Hawton, and Shepperd (2001) based on four counties (Northamptonshire, Berkshire, Buckinghamshire, and Oxfordshire) in England. The sample consisted of 27 individuals who died between July 1993 and June 1995; of the sample 24 died from suicide and three died of an undetermined cause. The majority of individuals were male (93%), nine were aged 15 to 19 years old, and 18 were aged 20 to 24 years old. Houston et al. conducted semi-structured interviews with parents, spouses, a sibling, and a psychiatric nurse, and gathered information from coroners' files, medical records,

and psychiatric files. Houston et al. (2001) reported that 17 individuals had engaged in previous self-harm and four individuals had self-harmed in the month before their death. It was found that suicidal ideas were, either directly or indirectly, communicated to other people (such as friends or relatives) in the year before the death of 16 individuals. Sexual abuse was known to have occurred in 18.5% of the sample. Of the sample, 74.1% had lived with both parents during adolescence (aged 13 to 18 years old). Just over half of the sample (52%) had been in trouble with the police at some time during their life. Houston et al. (2001) reported that 70.4% of participants had a psychiatric diagnosis, most commonly depressive disorders (55.5%), followed by a personality disorder (29.6%), with very few individuals receiving treatment. While substance use disorders were uncommon, a substantial proportion of individuals had difficulty with alcohol or other drug use. Houston et al. (2001) concluded that the suicides appeared to be the result of long-term difficulties extending back to the individuals' childhood or early adolescence, with psychiatric disorders, disruption of relationships with romantic partners, and legal difficulties relatively common factors in the suicides.

On occasion, young people under the age of 15 years old die from suicide. In 2012 there were 13 New Zealanders under the age of 15 years old who died from suicide; one male aged between five and nine years old, five females aged 10 to 14 years old, and seven males aged 10 to 14 years old (Ministry of Health, 2012). To investigate suicide in individuals under the age of 15 years old, Beautrais (2001) conducted a retrospective study of coroners' files of 61 New Zealanders who died over a 10 year period (1989 to 1998). The majority of individuals in this sample were aged 14 years (57.4%) and were males (72.1%) of Māori descent (57.4%). Beautrais (2001) reported that 13.1% of the sample had a prior known suicide attempt. It was found that

67.2% of those who died were not living within their biological home, and 23% had a psychiatric diagnosis. In addition, one in three (37.7%) were known to school, mental health, and/or welfare authorities to have significant problems. It was concluded that these deaths occurred within the context of actual or anticipated disruptions, or transitions in family living arrangements, or school circumstances, or severe family problems; the majority of deaths appeared to have been precipitated by relatively minor family arguments or disciplinary events (Beautrais, 2001). Overall, Beautrais (2001) concluded that those most at risk of suicide are a disadvantaged, vulnerable, and distressed group, growing up in extremely difficult circumstances.

The strength of psychological autopsies is that they allow the researcher to develop an understanding of any stressors which were present, while providing information on common factors amongst the individuals. This approach has reasonable validity and reliability (Brent, Perper, Kolko, & Zelenek, 1988). However, the process of a psychological autopsy is time consuming, with some interviews lasting over three hours (Houston et al., 2001). In addition, the information is often based on files contained within police reports and coroner's inquest findings, where there may be variations in the information available between individuals. Furthermore, it is possible that the information given to the researcher is not accurate, that those who provide the information are seeking explanations, or may see things that were not apparent beforehand, or that there is an interviewer bias present. Therefore, these results need to be considered cautiously.

Longitudinal Research

Longitudinal research is the process of repeated observations on the same individuals over a long period of time (Shadish, Cook, & Campbell, 2002) with the

benefit of providing information on a cohort as they age. Fergusson, Woodward, and Horwood (2000) conducted a longitudinal study of 1,265 children born in New Zealand, during a four month period in 1977. They looked at the data in relation to suicide and found that, by the age of 21 years old, 28.8% of the sample reported having thought about suicide, and 7.5% reported having made a suicide attempt. A strength of this particular research is that Fergusson et al. (2000) identified a profile of New Zealanders at greatest risk of suicide, namely, a young person raised in a family environment characterised by socio-economic adversity, marital disruption, poor parent-child attachment, exposure to sexual abuse, and who showed high rates of neuroticism. In addition, Fergusson et al. (2000) stated that depressive and anxiety disorders, substance use disorders, and conduct disorder, along with exposure to adverse life events, were significantly associated with the onset of suicidal behaviour. Their findings show that, for young people living in New Zealand, their risk of suicide depends on accumulative exposure to a series of social, family, personality, and mental health factors. Given that the data regarding suicidality was obtained in 1998 it is possible that some individuals were reluctant to discuss suicidality, due to the societal taboo. While, there are limitations to this research method, such as the time taken to collect the data and the possibility that repeated interviews influenced the participants' responses or behaviour this research provides valuable information.

Multiple-Group Comparison Study

To provide further information on the context of suicide, Beautrais (2003) conducted a multiple-group comparison study, comparing the risk factors for suicide and serious suicide attempts amongst three groups of participants. This study was based in New Zealand with participants, aged 13 to 24 years old, who were recruited from

Christchurch and the Canterbury region, during the period of 1991 to 1995. There were 60 individuals who, consecutively, died from suicide; the majority were males (81.7%), and the average age was 20 years old (*SD* = 2.53). Secondly, 125 participants, who had made a serious suicide attempt, were consecutively recruited, 57 were male and 48 were female, and the average age was 19.31 years old (*SD* = 3.1). Finally, there was a comparison group who were selected from a larger study on suicidal behaviour, which had been selected from regional electoral rolls. This group comprised of 151 participants, consisting of 78 males and 73 females with a mean age of 21.43 years (*SD* = 1.52). Semi-structured interviews were conducted with individuals who played a significant role in the participant's life. These interviews provided a retrospective life history and provided information on risk factors for suicide. Beautrais (2003) reported that, of those who died from suicide, 10% had made a previous suicide attempt. In addition, the majority (90%) had a recent stressful life event. Overall, Beautrais (2003) concluded that, based on the sample, suicides were characterised by male gender and stressful life events. Furthermore, Beautrais (2003) explained that the gender-related difference in suicides and suicide attempts were due to differences in the method of suicide. Specifically, 61.3% of male suicides and suicide attempts involved highly lethal methods (such as hanging or firearms), in contrast to 92.4% of female suicides and suicide attempts which were less lethal (typically self-poisoning). Lastly, Beautrais (2003) found other factors such as a mood disorder within the previous month, a history of mental health care, and lack of educational qualifications made a smaller contribution to the risk of suicide. The factors identified in this research are similar to those reported by Fergusson et al. (2000). A strength of this particular research is the inclusion of the participants who had attempted suicide, as it highlights the similarities with those who

died from suicide. However, a limitation of this research is the reliance of information given retrospectively and by significant others.

Young People's Perceptions on Suicide

Another approach to gain insight into youth suicide is to ask young people why they think their peers attempt, or die from, suicide; current methods for this include interviews and focus groups. A strength of this approach is the use of peers who are living within a similar environment as young people who die from suicide. In addition, peers can provide insight into the lives of young people, and can describe how they are affected by a suicide, which provides useful information on their grief and the support available.

Based in Australia, Bartik, Maple, Edwards and Kiernan (2013) investigated the experiences of young people who had lost a peer to suicide. They interviewed ten participants, two males and eight females, (M = 24 years, SD = 3.43) who had a peer die from suicide. The age of participants when they first experienced someone die from suicide ranged from 16 to 24 years old (M = 19.3 years, SD = 2.58). At the interview, the time since the participants' peer had died was between one and eight years. In total, the participants had experienced 24 suicides, 22 of these were peers and two were family members. This research considered the unknown element of suicide, with participants attempting to provide an explanation for their peers' death. Often, when someone dies from suicide their reason for acting lethally is unknown. This was emphasised by one participant who stated that "one of the unique things about suicide is that you never have an answer… like when they die, it's gone" (Bartik et al., 2013, p. 213). Through the process of narrative analysis, Bartik et al. (2013) identified four

themes. The first theme was “meaning making” (Bartik et al., 2013, p. 213), which referred to participants being unable to understand their peers’ death, and why they had not confided in them when they were feeling suicidal. The second theme of “feeling guilt” (Bartik et al., 2013, p. 213) related to the complexity of emotions that existed within their relationship with the person who died. The guilt was associated with the participant having not done enough, or being unaware that the individual was contemplating suicide. These mixed emotions later influenced how the participants interacted with the deceased person’s family members. An approach that participants used to manage their grief or guilt was to engage in “risky coping behaviour”, (Bartik et al., 2013, p. 214), which was the third theme. Bartik et al. (2013) reported this behaviour was frequently alcohol use, which began immediately after the death, and continued after the funeral. Furthermore, Bartik et al. (2013) reported that for many participants their alcohol consumption was at a dangerous level. In addition, participants were involved in risky sexual behaviours (such as having sex with people they did not know well), and some were engaging in self-harming behaviour (Bartik et al., 2013). The final theme identified was “relating to friends” (Bartik et al., 2013, p. 214) and the impact on current and future relationships with others. Participants struggled to relate to other people who did not understand what they had experienced, which negatively impacted on their socialisation. In addition, a longer term impact was the participants’ capacity to maintain a sense of trust within relationships. This research provided important information on how individuals can struggle to make sense of suicide, and how they are affected by the suicide of someone they know. While this study comprised of a small number of participants they had a high exposure to suicide, which would have provided a great level of insight.

In a similar study, based in South Africa, Shilubane, Ruiter, Bos, Reddy, and van den Borne (2014) interviewed 56 high school students (26 males and 30 females), between the ages of 13 and 19 years old, who knew a peer who attempted or died from suicide. They conducted two focus groups with participants whose peer attempted suicide and four focus groups with participants who had a peer die from suicide. Shilubane et al. (2014) used an inductive approach to analyse the data. Participants identified changes to their peers, such as sleeping during class, talking about death, a change in mood, and withdrawing from social interactions (Shilubane et al., 2014). The main factors that the participants believed to influence their peers' suicide were teenage pregnancy, punishment from parents, and attention seeking behaviour (Shilubane et al., 2014). In addition, Shilubane et al. (2014) identified that some participants were pre-occupied with suicide, which they attributed to the lack of support services available at their school. Shilubane et al. (2014) concluded that young people are usually the first to notice changes to a peer's mental health or risk of suicide; utilising peers as participants is a strength of this research method. However, in this instance the information was collected retrospectively. It is possible that, with hindsight, some participants identified changes that were not obvious at the time, and thus is a possible limitation to the research.

Based in the North of England and South Wales, Roen, Scourfield, and McDermott (2008) conducted 11 focus groups and 13 interviews with a total of 69 participants aged between 16 and 24 years old. The aim of this research was to pay attention to how young people made sense of suicide. Roen et al. (2008) did not seek participants with experiences of suicide, and utilised a general sample. Participants were drawn from pre-existing groups, such as youth groups, and were diverse in terms of gender, ethnicity, and sexuality. Through discourse analysis Roen et al. (2008)

revealed four frameworks for understanding youth suicide. The strongest theme that emerged was "suicide and the suicidal subject as Other" (Roen et al., 2008, p. 2091). Participants saw suicide as an event that was outside of their lives, and distanced themselves from people who were suicidal. Roen et al. (2008) related this distancing to the "shock" associated with suicide (Roen et al., 2008, p. 2091), that suicide was against the community's religious beliefs, and that suicide did not occur within "normal" families (Roen et al., 2008, p. 2091). In addition, participants commonly trivialised suicide by considering it as a cry for attention, describing it as "the cowards way out; an easy option; an understandable end to suffering; a perceived way out of difficulty or way to solve problems; a burden to those left behind" (Roen et al., 2008, p. 2092). The second theme, "suicidal subjecthood as readily accessible" (Roen et al., 2008, p. 2092), related to the notion of young people having permission for suicide to be a possibility. Rather than viewing all young people as suicidal it was understood as young people being able to contemplate suicide as an option. The next theme was "rationalising suicide" (Roen et al., 2008, p. 2094) where participants tried to understand the reason why the suicide had occurred. This was more about the search to find the reason rather than the actual reason, where participants believed that individuals had rationally chosen suicide as a way to manager their stressors. The final theme identified was "relationality and suicidal subjects" (Roen et al., 2008, p. 2095). This theme related to how participants felt an emotional responsibility to support someone, and to lead them to choosing life over suicide. In general, the participants concluded that, for their peers, suicide is only possible when it is imaginable.

Overall, these studies are valuable as they utilise young people as participants, explore how they make sense of suicide, and provide insight to youth suicide from a peers' point of view. The benefit of a sample consisting of peers is that they are the in

the same cohort as young people who die from suicide, are living within the same environment, and with the same resources available. In addition, it is likely that participants within the sample have personal insight into suicide, whether they have had suicidal thoughts, an attempt, or know someone else who has, and they provide valuable information on the context of suicide which further develops the understanding of youth suicide. Given that the rates of youth suicide within New Zealand are not decreasing, and the unique culture of New Zealand there is an interest in exploring young people's perceptions on why their peers attempt, or die from, suicide.

The aim of this research was to gain a deeper understanding of youth suicide within New Zealand by exploring why young people think their peers attempt, or die from, suicide. Participants were individuals aged 16 to 24 years old residing in New Zealand. Specifically, this research asked participants which contextual factors they believe influence young peoples' suicidal behaviour. It was expected that participants' views would provide additional information on youth suicide within New Zealand. This information may be used to create more awareness on youth suicide and could then, in the future, be used for education and the development of further suicide prevention campaigns.

Chapter 3

Method

This chapter will outline the procedure, methods, and engagement with participants, throughout the process of this research. An explanation of the data collection and analysis is included. Additionally, the ethical issues of this research, and how they were managed, are discussed.

Research Approach and Design

The purpose of this research was to develop a deeper understanding of youth suicide within New Zealand, by exploring why young people think their peers attempt, or die from, suicide. Previous research within this field has obtained valuable knowledge through the use of focus groups. Focus groups allow for in depth discussions and the development of broad insights (Savin-Baden & Major, 2013). In addition, focus groups, when compared with individual interviews, allow for information to be generated quickly. Therefore, the design for this research was to utilise focus groups, with participants aged 16 to 24 years, as it was anticipated that this would provide a good flow of conversation and ideas amongst the participants.

Recruitment Process

I sought permission to advertise within youth organisations (such as Evolve and Zeal) to recruit participants (see Appendix A for an example). Then, advertisements (Appendix B) were placed at various organisations. No advertisements were placed within schools. In addition, I asked family members and friends to share the

advertisement with possible participants to utilise snow-ball recruitment. Potential participants made contact via emails, text messages and/or phone calls, and were provided with the information sheet (refer to Appendix C). The information sheet provided information on the aim of the research, the process, and participants' rights. The criteria to participate were being between the age of 16 and 24 years and fluent in English. Once an individual was assessed as suitable to participate they were advised of the time and location of an upcoming focus group. During this process I ensured that participants had read the information sheet and were aware of what their participation would involve (discussing their views on youth suicide, amongst other participants, whilst being recorded). In addition, I asked if they knew of any other individuals who would be interested in participating.

Throughout the recruitment process I began making connections with the participants in order to build rapport before the focus group took place. Focus groups were held at the earliest convenience where there were at least four participants who stated they were able to attend. For five of the focus groups the participants knew each other; focus groups are discussed below.

Focus Groups and Participant Details

There were six focus groups, held between 20th September 2015 and 13th October 2015, with a total of 19 participants recruited from Wellington, Sanson, and Wanganui (New Zealand). The age of participants ranged from 16 to 24 years old, with a mean age of 19.74 years (*SD* = 5.04). Table 2 provides participants' details, including their chosen pseudonym, gender, age, ethnicity, and employment status.

Table 2

Participant Information (N=19)

Pseudonym	Gender	Age	Ethnicity	Employment Status
Focus Group 1				
Christine	Female	18	NZ European	Tertiary Student
Tim	Male	19	NZ Pakeha	Tertiary Student
Focus Group 2				
Dillon	Male	18	NZ European	Beneficiary
Kate	Female	16	NZ Māori	Secondary Student
Maddy	Female	18	NZ European	Farm Worker
Mishayla	Female	16	NZ European	Secondary Student
Focus Group 3				
Beth	Female	21	NZ Pakeha	At Home Mum
Candy	Female	24	NZ Pakeha	Healthcare
Sami	Female	22	NZ Pakeha, NZ Māori	Beneficiary
Shanti	Female	24	NZ Pakeha	Healthcare
Tami	Female	24	NZ Pakeha	Hospitality
Focus Group 4				
Ashleigh	Female	23	NZ European	Healthcare
Jane	Female	24	NZ European	Healthcare
Sharolyn	Female	23	NZ European	Healthcare
Focus Group 5				
Amber	Female	22	NZ European	Healthcare
Jack	Male	22	NZ European	Government Employee
Kelly	Female	22	Indian	Tertiary Student
Focus Group 6				
Lisa	Female	20	Chinese, Tokelauan, NZ European	Tertiary Student
Sally	Female	20	NZ European	Tertiary Student

Procedure

Focus groups were conducted at a location that was mutually agreed upon. Two were held at a room located at Massey University, Wellington campus. The remainder took place in residential properties as this was the most convenient for the participants. While focus group one consisted of strangers the participants in the remaining focus groups knew each other (friends or flatmates). Before each focus group began I ensured that each of the participants felt comfortable and safe. The rooms were large enough to accommodate the participants and recording equipment (described below) comfortably, and, given the nature of the discussion, were sound-proofed or in a house where no other people were present.

I greeted each participant as they arrived. Once all participants were ready we reviewed the information sheet and I provided each participant with a consent form (Appendix D). As participants completed the consent form I recorded their age, sex, ethnicity, and employment status. The consent form required details for a support person who could be contacted should the participant become distressed. I checked that each participant understood the consent form. I asked each participant if they had any questions; none of the participants had any questions about the research process. In addition, I asked participants to choose their pseudonym, allowing them to choose a name they identified with, and explaining that this was to help with anonymity of their participation. I then reiterated points from the information sheet and consent form, regarding the process should they become distressed, and their anonymity. I explained that each person would be given the opportunity to speak, and asked participants to be mindful of talking over each other.

Focus groups were audio-recorded using a Sony ICD-UXS43F digital voice recorder and video recorded using a Panasonic SDR-H85 camera. The addition of the video recorder provided the ability to match voices to faces. I positioned the audio recording device between the participants and myself, and the video recorder in the corner of the room so that all participants and myself were visible within the screen. At each focus group participants were asked if they wanted to begin or finish with a karakia, no participants wished for this. Snacks and non-alcoholic drinks were provided for each focus group, and participants were encouraged to help themselves to these throughout the discussion. I then began the focus group, reminding participants that the research had a focus on young people, aged between 16 and 24 years old, living in New Zealand. The focus groups followed the questions based on the interview schedule (Appendix E), while allowing for flexibility and follow up questions depending on the topic being discussed. The discussion began by asking participants what they knew about youth suicide within New Zealand, and how they were aware of the information. Following this, participants were asked what situations they thought might influence a young person's suicide (such as: bullying, alcohol or drug use, intimate relationships, mental illness, and school or family stressors). These situations were based on findings in previous research, identified during the literature review completed prior to the focus groups.

During the focus groups participants were asked if they had a personal experience with suicide, and if they wished to share that within the group. The majority of participants spoke of personal experiences with a family member, friend, or peer attempting, or dying from, suicide. No participants were visibly distressed during the focus group. Before participants left I spoke with those who shared their experiences (individually) to ensure that they were not distressed before leaving; each participant

advised that they felt safe to leave the venue. Finally, I thanked each participant for their time, honest responses, and discussions regarding youth suicide. Each participant was given the opportunity to ask questions, while I provided them with a list of support organisations who could be contacted (Appendix F). Each participant was given a $20 New World voucher to thank them for their time and contribution. I obtained the contact details for each participant in order to provide a summary once the research is completed.

Ethics

Ethical approval for this research was granted by the Massey University Human Ethics Committee: Southern A (15/26; see Appendix G). Due to the sensitive nature of the research there was a delay in ethical approval being granted, as the board considered how the safety of participants would be maintained during the focus groups.

As suicide is a sensitive topic it is necessary to consider the ethical implications of researching within this field, to avoid unnecessarily harming the participants, and/or the researcher. While I did not seek participants who had a personal experience with suicide, such as knowing someone who had attempted, or died from, suicide, or having contemplated or attempted suicide themselves, I did not exclude them either. Excluding participants who had an experience with suicide could have limited the number of possible participants within the sample population. In addition, it would have excluded participants who, as a result of their experience, had formulated views on youth suicide within New Zealand.

During recruitment, advertisements were not placed at secondary schools as young people under the age of 16 years old may have seen them. If this occurred it was

unknown how the information on the advertisement would affect them, or what support would be available if they became distressed.

While signing the consent form, participants identified the name and phone number of a support person who could be called in the event that they became distressed. No support people were called. After each focus group I contacted my supervisors to advise that it was completed. In addition, I ensured that I took regular breaks during the transcription process.

Data Analysis

Each focus group resulted with a video and audio file. The files were saved on a password protected computer. The audio recordings were transcribed verbatim using the Express Scribe software programme, and listened to through headphones. Names, places, and other identifying features were given pseudonyms or removed, to ensure anonymity. One focus group was transcribed with the addition of the video file as there was difficulty identifying who was speaking. Final transcribed documents were then saved as a Word document, on a password protected computer.

The research approach was qualitative to provide a deeper understanding of youth suicide in New Zealand, by exploring why young people think their peers attempt, or die from, suicide. As the interest was in the participants' views thematic analysis was used to identify themes. The analysis process followed five phases: familiarisation with the data, coding the data, searching for themes, reviewing themes, and defining and naming themes (Braun, Clarke, & Terry, 2015). Following is a discussion of each of the phases.

Phase 1: Familiarisation with the data: This was a process of immersion with the data, where I read, then re-read, the entire transcript from each of the six focus groups. This phase was two-fold, as it enabled me to become familiar with the data, and began my analytical engagement with the data (Braun et al., 2015). Through the transcription process I understood the data; once I began to treat the data analytically I moved to phase two.

Phase 2: Coding the data: Coding is a systematic process where codes are derived from the entire dataset (Braun et al., 2015). A code is a succinct label (of one or a few words) that captures a key analytical idea in the data and communicates this to the researcher (Braun et al., 2015). The purpose is that the code conveys the key idea from within the data without the researcher needing to see the data (Braun et al., 2015). Each of the six transcripts were coded one at a time, line by line, with codes recorded within the margins. This process began with my supervisors where, while keeping the research question in mind, we coded together to ensure consistency. The transcripts were coded at a basic level, without any meaning associated to the code. A total of 98 different codes were identified (see Appendix H for a full list of codes). Then, I re-coded the entire dataset to ensure that I had consistently coded each transcript. Following this step the information was transferred to Excel. I recorded the code, the number of the focus group and line number, and the excerpt from within the transcript. There were a total of 558 excerpts, categorised into 98 codes. The Excel document was then saved on a password protected computer.

Phase 3: Searching for themes: This phase shifted the analytical focus from codes to themes, with a theme identifying a broader level of meaning than a code (Braun et al., 2015). In this phase, codes with a similar meaning were clustered together, such as codes that related to internal factors (emotions or mental illness). As a result, five themes, each with subthemes, which captured the majority of the codes, were identified.

Phase 4: Reviewing themes: This phase was a two-step process, where I checked the coded data to ensure it developed the theme, and then re-checked the entire dataset to confirm that the themes reflected meaning across the whole dataset (Braun et al., 2015). Through discussion with my supervisors, these themes were re-organised to provide a more coherent picture of the data.

Phase 5: Defining and naming themes: In this phase, the data of each theme was analysed, which refined its focus and scope to determine the story of the data (Braun et al., 2015). I identified which transcript extracts demonstrated how the discussion related to each theme. Lastly, I ensured that the themes did not overlap, but related to each other in order to provide a coherent analysis (Braun et al., 2015).

Chapter 4

Results

Thematic analysis of the focus group discussions identified five themes: relationship factors, internal factors, gender, external factors, and support services. Each theme had two subthemes, as shown in Table 3. To highlight the strength of the themes, they are listed in descending order. The strength was based on the length of discussion and how strongly participants voiced their opinions. The themes are discussed in turn below using excerpts from the transcripts as evidence. For the sake of clarity, interviewer interjections that did not add meaning or influence the discussion (e.g. "mmmm" and "ok") have been removed from the excerpts. For each excerpt, the participant's focus group is provided (e.g. group two).

Table 3

Themes and subthemes within participants' discussions about suicide

Themes	**Relationship Factors**	**Internal Factors**	**Gender**	**External Factors**	**Support Services**
Subthemes	Bullying	Depressive Disorders	Kiwi Masculinity	Alcohol and other drugs	Access
	Intimate relationships	Coping Skills	Rates	Circumstances	Reluctance/ Barriers

Relationship Factors

This theme encompassed the ways in which participants believed that relationships with others influenced their peers having thoughts of, or attempting, suicide. There were two subthemes: bullying and intimate relationships. Overall, it was the dynamics of the relationship, with a bully or intimate partner, and the manner in which they perceived the relationship, that participants believed led an individual to contemplate suicide.

Bullying

In each focus group the topic of bullying was discussed in detail. Participants identified an increase in cyber bullying and discussed some reasons for bullying. When participants were asked why they thought young New Zealanders might contemplate suicide their initial responses were typically that bullying influenced suicide; such as Mishayla (group two) who stated that "it's from bullying usually". Christine (group one) felt strongly about the relationship between bullying and suicide, she asked:

> Christine: isn't that one of the leading reasons like young people, well people in school commit suicide, like wouldn't that be one of the main things?

Bullying from peers was consistently identified by participants throughout each of the six focus groups. Participants who were still at secondary school, or who had recently finished their schooling, discussed the concept of bullying in more detail. When participants identified bullying as a possible influence of suicide I clarified whether they were talking about the bully or the individual being bullied, and all 19 participants agreed that it was the victim of the bullying who was more likely to contemplate suicide

rather than the bully. This differs from the research of Kaltiala-Heino et al. (1999) who identified that a bully had the highest risk of suicide.

Some participants identified that bullying is not limited to face to face interactions and discussed the impact of cyber bullying. Maddy (group two) referred to individuals who bully via social media as "keyboard warriors". This terminology implies that cyber bullies are braver than they would be in person, as being behind a computer gives them a sense of strength, like a warrior. Dillon (group two) continued, and explained how social media makes it easier for people to bully others:

> Dillon: I guess a lot of it's probably off Facebook and that, like people not being able to do it in person, as much anymore, like with all the internet and that, and different social medias and that, it's probably easier to do it through that.

A significant number of young people utilise social media, specifically Facebook. Many young New Zealanders have a cell-phone and are able to consistently access social media (such as when at school or at home). Given the amount of time that young people spend engrossed with social media this increases the possibility that they will experience cyber bullying. Another possibility for the increase in cyber bullying is the ease at which it can be done, it can be carried out by people who would not otherwise bully in face to face interactions, and provides them with a sense of bravado. Lastly, cyber bullying provides anonymity, which may have led to its increase. Some participants, such as Sharolyn (group four), discussed how cyber bullying removed accountability:

> Sharolyn: I think social media and, that kind of stuff makes it a lot worse these days as well cause it's from people who, they kind of just,

can get away with it because they don't really hold any accountability for it, they can just do it from wherever they are at home and not have to actually face up to it.

Participants' talk suggested that they saw lack of accountability as influencing the continuation of cyber bullying. The anonymity of cyber bullying, and belief that they would not be held accountable for their actions, can result in cyberbullying that is more malicious than that experienced in face to face interactions.

Some participants discussed possible hypotheses for the occurrence of bullying, such as "wearing different clothes", "a different hair cut", "being overweight", or a "mental illness". This was important as participants highlighted a wide variety of factors that can influence bullying. Sally (group six) felt that bullying was related to an individual's sense of security:

Sally: a lot of kids feel insecure and either bully others, or are insecure and people pick up on that and bully them.

Peer relationships are very important for young people as they want to feel accepted. Sally's reference to insecurity highlights how she views this as a reason for both being bullied and being a bully. Sally and Lisa (group six) discussed this further:

Sally: everyone wants to feel like they fit in, everyone wants to feel like they belong …[1] I think it comes back to acceptance and fitting in

Lisa: you don't feel, validated or you feel like your society doesn't validate your identity, then, there's no way that you can be happy.

[1] Indicates that some of the excerpt has been removed.

Sally and Lisa highlight the importance of a young person's identity and how a lack of acceptance can influence the way they feel about themselves. Young people feel a need to belong to their peer group and their peers provide a sense of validation. It is possible that when young people do not feel a sense of belonging, or that they are accepted by their peers, or that their identity is being judged, they contemplate suicide.

Lastly, some participants, particularly focus groups one and six, discussed how young people can experience bullying due to their sexuality, and being different from the expected societal norm. Similar to the research of Russell and Joyner (2001), Christine (group one) believed there was a relationship between homosexuality and suicide:

> Christine: gay youth are way more likely to attempt suicide because of bullying and such.

Christine identified that, along with the bullying experienced, there are other issues that influence suicide in homosexual youth. This is consistent with research by McDaniel et al. (2001) who found that homosexual youth had maladaptive coping skills which increased their risk of suicide. Furthermore, Christine and Tim (group one) discussed the risk of suicide for young people who are transgender:

> Christine: I feel like they are probably even more at risk, than like, well transgender people are even more at risk than gay people … Cause I feel like transgender is something that, is, you know, that some people consider even more weird than gay, and like, I guess that sometimes it's quite, apparent when someone's transgender. Yeah, it's easier to sort of disguise, I guess.

Researcher: So do you think they are more at risk because of how they feel within themselves or because of how people treat them?

Christine: It's because of how people judge them, you know?

Tim: I reckon it is like internal as well, like they feel like they're different and so, that's hard on them and they feel like they can't connect with other people, whether that is the case, or fear that other people won't accept them.

Christine identified that some people accept an individual who is homosexual but find it difficult to accept someone who is transgender, because it is "more weird". Christine and Tim believe that the increased risk of suicide for transgender individuals is a result of both the way that society judge them and the way they feel about themselves, because of their difference. It is important to consider why society struggle to accept transgender individuals. Also, Sally (group six) discussed why she thought the bullying of transgender individuals occurred:

Sally: I know some people bully people because they don't understand, so if a bully doesn't understand why men wanted to wear high heels or nail polish I can see why they would, pick on them a little bit more, and make them feel even more less accepted.

This lack of acceptance, and the associated comments and behaviours, can negatively influence a young person, as they feel judged, or fear that because they are different they will not be accepted, or will not be able to connect with their peers.

Overall, the majority of participants believed that there was a causal relationship between bullying and suicide, with the victim more likely to contemplate suicide. They

believed that cyber bullying was becoming more prevalent because of easier access to technology and the anonymity that it provided.

Intimate Relationships

The majority of participants discussed how the negative thoughts or emotions that arise from the break-up of an intimate relationship could influence suicidality; Beautrais (2001) found an association between the break-up of an intimate relationship and suicide. Specifically, Christine (group one) discussed how an intimate relationship break-up could influence suicidal thoughts:

> Christine: I think people's first relationships, like first proper relationships are, often quite intense, and like, I guess if you get dumped then people can, they can easily push people who maybe have depressive tendencies already into like a pretty major depression.

Christine referred to "first proper relationships" which infers that the difficulty arises from it being the first experience of a relationship dissolution rather than the fact that the relationship ended. Christine focuses on individuals who have depressive tendencies and implies that it is only these people who can become suicidal after an intimate relationship ends. Other participants spoke of their own experiences, such as Tim (group one):

> Tim: I remember umm when I broke up with one of my ex-girlfriends a while ago, and I was like pretty cut and then, but I felt better cause like I got so much support that I didn't even feel like I had, you know?

Tim reflected how he was affected by a relationship break-up and how he was able to utilise his support to manage his distress. He highlights how he has had more than one intimate relationship break-up, and implies that regardless of whether it is the first or a later relationship the individual can still be affected. Beth (group three) felt that her friend's suicide was influenced by an intimate relationship she had:

> Beth: She was like mainly her boyfriend was umm not horrible but they used to like they were on and off and that and she's just you know young and in love or whatever, umm, yeah, obviously no one knows like why, she, actually why, but yeah she just hung herself.

While Beth identifies that being in a relationship that is "on and off" can influence suicidality she states that "obviously no one knows like why" so cannot provide any definitive reasons. It is possible that the combination of emotions related to the changeable nature of the relationship and being "young" influenced this suicide.

Overall, participants believed that the difficulties experienced as a result of an intimate relationship break-up could influence suicidality. In conclusion, intimate relationships are complicated, and young people need love and support from their peers and family, and foresight to manage the difficulty of a break-up.

Internal Factors

This theme consisted of participants trying to understand the context of another young person's suicide by considering internal psychological factors. There were two subthemes: depressive disorders and coping skills.

Depressive Disorders

Some participants discussed depressive disorders as a possible influence on suicidal behaviour. Christine (group one) identified a relationship between depressive disorders and suicide:

> Christine: well I guess if you commit suicide you're almost certainly depressed right.

Christine believes that being depressed has a significant influence on suicide. However, other participants disagreed with a causal relationship between depressive disorders and suicide, such as Sharolyn (group four):

> Sharolyn: I don't think you have to have depression to commit suicide … Like a young kid has done something that they think is really bad that they don't want to tell anyone about, they might not necessarily be depressed about it, they might just feel, be feeling kind of scared, like, that they don't want to own up to something or I don't know, they maybe just think it's a lot worse than it is. I don't think that's depression per se, but you don't hear about that kind of thing.

Sharolyn identified that an individual can have suicidal thoughts without the presence of a depressive disorder, highlighting the complexity of suicide and that other feelings are equally important to consider, such as shame. Sharolyn introduced how the relationship between depressive disorders and suicide is often portrayed, such as through the media:

> Sharolyn: I feel like I have seen media that makes out that depression kind of leads to suicide and suicide is caused by depression, that kind of thing but, I don't really see anything about like, other types of

suicides so maybe someone is, like a young kid has done something that they think is really bad.

The media reinforce the belief that there is a causal relationship between depressive disorders and suicide. Sharolyn identified that depressive disorders are not the only factor relevant to suicide. Previous research, such as Shahtahmasebi (2003) found that, of the sample who died from suicide, only a small proportion had a diagnosis of a depressive disorder. While there are other causes of youth suicide, the lack of media representation implies that this does not occur.

Overall, some participants were aware of a relationship between depressive disorders and suicide. However, some believed it to be a causal relationship, largely due to media portrayal.

Coping Skills

Throughout each focus group participants discussed coping skills, specifically the lack of coping skills young people have. This was related to variables such as an individual's age, attention seeking, or viewing suicide as a viable option. Some participants, such as Maddy (group two), discussed how they believed suicide to be the result of someone "taking the easy option". Sharolyn (group four) spoke of this too:

Sharolyn: probably cause they don't want to, deal with any more problems after something big has happened and then, you know, they just want to take the easy way out of it and so they just commit suicide…Maybe it's that they feel they are not supported or that they, don't see another option even though I am sure there are a lot of options for them.

Sharolyn identified that suicide can be the result of a difficulty in speaking about problems. By stating that a young person can "just commit suicide" it implies that this is an impulsive, rather than a well-planned, decision. This is contrasted to the view of Tim (group one):

Tim: so I guess suicide is like that kind of, you know last resort.

While it is unclear whether Tim considered that individuals had canvassed other options before suicide, he highlights how an individual can believe that suicide is the last resort only way to avoid their current situation. This is similar to research by McLaughlin et al. (1996) who reported that 38% of their sample (of people who had attempted suicide) were unable to think of an alternative to suicide. Participants in focus group four discussed how they felt suicide could be a selfish act.

Maddy: yeah, it's just being selfish to yourself.

Kate: it's just passing on the pain to someone else

Dillon: yeah, and everyone else that gets affected by it.

These participants describe a young person in pain who, rather than seeking support, attempts suicide, which participants view as selfish. This selfishness relates to the inability to consider how their death will impact on other people. Furthermore, some participants discussed how suicide can be viewed as seeking attention. Christine (group one) spoke of her personal experiences:

Christine: I think there were some attempts when I went to boarding school, they were like, they were just, they weren't serious, they were like, I took a box of Panadol, give me some attention type thing.

A suicide can be trivialised, and an attempt can be considered as attention seeking behaviour. In some cases, this attention seeking behaviour can have a fatal result. Suicide attempts must be considered seriously. Sally (group six) also discussed how a suicide attempt could be considered:

> Sally: a cry for attention, don't want to ask for help but, want someone to notice, someone to care, someone to see it, and to feel like you're ok, because they don't feel like they can ask for help.

Sally identified that there can be barriers to asking for support when feeling suicidal. Quite simply, a young person may not seek support because of fear of judgement or due to societal stereotypes.

In focus group four Sharolyn and Ashleigh discussed how age can impact on coping skills:

> Sharolyn: I suppose we guess we have a bit more judgement at our age but we are still kind of in that spectrum of like, things can seem a little bit, I don't know, like when you're a teenager obviously things feel like they're the end of the world and we still kind of go through that at times cause we obviously haven't lived quite as long and realised that you can get through things, that we might not think we can.

> Ashleigh: yeah, it's being irrational about thoughts, not really thinking about the future, they just think about right now because it's a hard time already, and they don't realise that it's going to pass, and it will be alright in the future, they just can't plan or forward think.

Sharolyn and Ashleigh discuss how age positively influences a young person's perceptions of the future, as they have past experiences to draw upon. It is likely that the coping skills that develop with age and experience enable a young person to manage difficult situations.

Overall, participants believe that depressive disorders may play a role in suicide. While some participants stated a causal relationship this was not consistently identified. In addition, some participants discussed how a lack of foresight, and a lack of managing difficult situations, impacts on youth suicide within New Zealand. This is similar to a comment made by a young person in "Target Zero" (King, 2015), that he "couldn't see a light at the end of the tunnel".

Gender

This theme concerned the ways in which participants talked about gender and suicide, and it had two subthemes: kiwi masculinity and suicide rates. Participants identified a New Zealand stereotype related to kiwi masculinity, and the impact this has on young males. In addition, participants were aware of the difference in rates between males and females and offered possible reasons for this.

Kiwi Masculinity

Participants discussed how young New Zealand males are portrayed within society, and how the stereotype can impact on whether they access support. In general, participants agreed with the statement made by Tami (group three) that males "are

portrayed to harden up", which was emphasised in "Target Zero" (King, 2015). Christine (group one) believed that:

> Christine: New Zealand men, like there's this just this stereotype, of you know being tough or whatever, and macho.

There is a need to be perceived as "tough" or "macho". It is likely to negatively impact on whether a young male displays any emotional vulnerability. Sharolyn and Jane (group four) also spoke of this:

> Sharolyn: Like in New Zealand we kind of have that perception of like this macho male who plays rugby and does DIY and all of that, and lots of farming communities and that kind of thing, and like, that is why maybe a lot of young boys are kind of not ok with talking about things because their Dads have always been like oh we don't talk about that kind of stuff.
>
> Jane: New Zealand men have that reputation, but I think it's even stronger, in, so maybe, they're just yeah, they have that like, to protect their image kind of thing.

Sharolyn discussed how this stereotype is generational and that young males are modelling the behaviour of their fathers. In addition, this stereotype is specific to New Zealand culture. Given that New Zealand has such a high rate of youth suicide these are important points to consider. There is an implication that "macho" equates to masculinity, and being perceived as not being "macho" equates to being weak. Sally (group six) discussed males who cry:

Sally: I see girls being upset as a bit more accepted socially than it is, if you see a guy crying it's a little less acceptable, yeah, it's a bit more stigma against guy being upset than girls.

The stereotype of kiwi masculinity portrays a male who cries as vastly different to a female who cries, and is less socially accepted. A fear of being perceived as weak may result in a reluctance for a young male to seek support.

Finally, Candy (group three) discussed the difference between how males and females manage their distress:

Candy: guys would be probably more embarrassed so don't want to speak up about it.

Candy identified that the reluctance for a young male to seek support could be due to the thoughts and emotions they believe will result from asking for help, which is reinforced by this stereotype.

Overall, participants identified a kiwi masculinity stereotype and how males needed to be "macho" to conform to society's expectations. The need to "harden up" and possible embarrassment in expressing distress is likely to negatively impact on young males, and influence the rate of male suicide within New Zealand.

Rates

Some participants discussed the rate of suicide in New Zealand, and identified a difference between males and females, such as Jane (group four):

Jane: I feel like I've read this, that boys tend to, to have more of a serious attempt and that is therefore more successful, whereas the methods I guess that girls sometimes choose is not as, successful.

This is consistent with New Zealand statistics. Jane identified how the lethality of the method can impact on the success of a suicide. This is consistent with the research of Beautrais (2003), who found that males use more lethal methods for suicide. Christine (group one) also provided a possible explanation for the difference between the rate of male and female suicides:

Christine: it might be like not relevant to New Zealand but I've just, some, I think I was reading a document about suicide once and it said that when girls commit suicide they tend to do it in ways that might, of a certain, this isn't a conscious decision I don't think, but ways that won't like ruin their face, and so like, are less inclined to shoot themselves in the head, I guess, so maybe that's part of why male attempts are more successful, but I don't really know.

While Christine believes that it may not be relevant to New Zealand she raises a valid point, that females are concerned with their appearance, even in death, and carefully consider their means of suicide, to preserve their image. Both Jane and Christine reported reading this information, demonstrating how the knowledge that young people have on suicide often comes from the media, and the importance of accurate representation.

Overall, participants identified that New Zealand has a stereotype on kiwi masculinity, and that this can impact on a young male's willingness to acknowledge, and address, their distress or suicidality. Participants were aware that New Zealand

males die from suicide at a higher rate than females, and believed that the method of suicide influenced this.

External Factors

This theme was about the contextual factors that participants believed were an influence to suicide. There were two subthemes: alcohol and other drugs and circumstances. Some participants felt that the context, such as impaired judgement (from alcohol or other drug use), or having experienced a stressful or traumatic event, provided contextual factors that played a role in an individual's suicide attempt.

Alcohol and Other Drugs

The majority of participants discussed how they believed alcohol and other drugs were an influencing factor in suicide. Tami (group three) and Jane (group four) both stated that alcohol and other drug use can "cloud your judgement". A young person may have thoughts of suicide which are exaggerated when under the influence of alcohol or drugs, as they may not think rationally and suicide may appear a viable solution. Christine (group one) discussed this:

> Christine: drugs and alcohol can play a huge role in some peoples' like you know, sort of, downward spiral … get really wasted to try and give themselves the courage to do it.

This implies that alcohol or drug use can provide a sense of bravery, and that suicide is not an "easy" decision, like other participants discussed. Ashleigh and Sharolyn (group five) recalled their friend who died from suicide:

Ashleigh: what I concluded in my head was that drugs and alcohol had a big factor, in it.

Sharolyn: he did drink a lot, and take a lot of pills and things … if he had support and if he didn't do drugs and alcohol the whole night before then I definitely think he'd be in a different space.

This is an example of a young person who died from suicide when under the influence of a "lot" of alcohol and drugs. His friends believe his alcohol and drug use was a contributing factor. This relationship has been established in previous research, such as Shaffer et al. (1996) who found that 82% of their sample had alcohol or drug use, or a diagnosis of a substance use disorder. Unfortunately, this highlights how the appropriate support could have saved his life.

These participants emphasise how alcohol and drug use can become a maladaptive coping strategy. They identify the danger of alcohol and drug use when suicidal, as it "clouds judgement", and the need for targeted support.

Circumstances

Participants discussed a variety of circumstances which could influence a young person's suicidality. In general, participants thought there must be a reason for a suicide, such as Sally (group six):

Sally: normally there's one thing that happens that makes you tip over, I guess.

Adolescence is a period of change and young people must navigate difficult situations. Suicide can be the culmination of a number of events, or as Sally identified, the result of

a single incident. Ashleigh (group four) thought that a suicide could be due to a specific situation:

> Ashleigh: trying to get out of a situation, they don't like being in, can't really think of an example, maybe they've done something really bad, they think it's bad in their head, and they just want to get out of the situation.

Although Ashleigh could not identify a specific situation she discussed how the stress or anxiety of the situation can influence suicidality. Previous research found that 90% of the sample of young people who died from suicide had recently experienced a stressful event (Beautrais, 2003). Participants viewed suicide as a viable option to solve their problems.

Christine (group one) discussed possible reasons for the higher rates of suicide by New Zealand Māori:

> Christine: the higher rates of poverty and domestic abuse … I guess a lot of people who are brought up in horrible situations expect to just have a shitty life forever.

Christine refers to Māori having higher rates of poverty and domestic abuse, which could be related to their poorer health status (Chappel, 2000) or as a result of the process of colonisation (Reid & Robson, 2000). Christine continues to discuss the impact of "horrible situations" and how the environment can negatively influence a young person's suicidality.

Participants identified various factors that influence youth suicide in New Zealand. In general, participants recognised that alcohol and other drug use impacts on

suicide. Without the appropriate support to manage stressful circumstances suicide can occur.

Support Services

Participants also discussed the support services available for suicidal youth within New Zealand. Participants discussed the appropriateness of these services and a young person's reluctance to access them. There were two subthemes: access and reluctance/barriers.

Access

This subtheme related to a young person accessing support. Some participants discussed young people's perceptions on accessing support, such as Sharolyn and Ashleigh (group four):

> Sharolyn: I think definitely knowing that other people have the same issues, knowing that you're not the only person who feels that way, um, and yeah, talking to your friends and to mum
>
> Ashleigh: yeah definitely friends, and parents, but I also had friends that I could talk to.

These participants identify the benefit in talking to someone trustworthy and how knowing that other people are in a similar situation can be valuable. A young person can seek support from someone they believe will help; they do not need to be a professional.

Participants in focus group four spoke about the New Zealand based campaign, fronted by Sir John Kirwan, which raises awareness for depressive disorders and how young people view it:

Sharolyn: I feel like a lot of young people don't resonate with him cause they don't really know who he is

Ashleigh: yeah, he's a bit old

Jane: mmmm, something more, for people that they feel they can relate to.

The campaign on depressive disorders is aimed at older males so young people may not know who Sir John Kirwan is, may find him too old, or may not relate to him. These participants felt that it would be beneficial to have a similar suicide prevention campaign, aimed at young people. Given New Zealand's high rates of suicide for young people aged 16 to 24 years old it is necessary to develop a suicide prevention campaign with the appropriate spokesperson.

Reluctance/Barriers

Some participants spoke of the barriers that young people can experience in regards to accessing support, such as Kelly (group five):

Kelly: cause they don't know where to go to get help.

It is possible that an individual wants support for their suicidality but does not know how to go about this due to a lack of advertising and awareness. This supports the need for a targeted campaign which provides this information.

Sharolyn (group four) discussed her thoughts on a reluctance to seek support:

Sharolyn: I feel like, personally I think what we need to really work on is, dealing with our issues in New Zealand about not talking about things, because you look somewhere like America like I'm sure they have a lot of issues with suicide as well but the first thing they do when they have an issue, they go see a psychiatrist or they, they go and talk to this person, they go and talk to that person, but for some reason here in New Zealand we don't do that we have all these things that are almost taboo.

Sharolyn identified that young New Zealanders may be reluctant to access support because of the taboo that is associated with being suicidal. This will be especially difficult for males, due to the stereotype of kiwi masculinity.

In addition, Amber (group five) discussed the financial cost of accessing support:

Amber: your GP would probably be the only starting point people sometimes can't afford that, people are poor, you know a student person.

While Amber refers to students there are other young people who may not have finances available to access support, such as those of low socio-economic status. Young people may not be aware that support services can be accessed free of charge. It is likely that limited funds will greatly impact on seeking support. Some participants discussed New Zealand phone lines, such as Sharolyn and Ashleigh (group four):

Sharolyn: there is support but I don't know that people feel like, it's for them, like people kind of see it and think oh yeah but no not me I

wouldn't call that, or, especially young guys who wouldn't think, oh no I'm not going to call up that.

Ashleigh: yeah like what will they do to help, what's a phone call going to do? That's probably what they think.

Sharolyn and Ashleigh discuss how young people might not feel comfortable to speak with a stranger, as they may not think it will be helpful. If they were aware of the validity of this service they may be more likely to access it.

Overall, participants identified that there are supports available but they are not well advertised or are hard to access. Participants identified the need for a campaign targeting suicide, fronted by someone who young people will resonate with.

Chapter 6

Discussion

Early intervention with young people who are displaying suicidal behaviours is the most effective strategy for preventing suicide (Fortune, Seymour, & Lambie, 2005).

The aim of this research was to develop a deeper understanding of youth suicide within New Zealand. Participants discussed suicide of their peers from their point of view. Results showed that participants discussed five main themes, namely relationship factors, internal factors, gender, external factors, and support services. These will be discussed in relation to previous research. In addition, this chapter provides recommendations, limitations and possibilities for future research.

Participants' discussions identified how the complexity of relationships, with bullies and intimate partners, can influence suicidality. Many participants believed that there had been an increase in cyber-bullying and that bullying was a primary factor in youth suicide. All participants believed, within a bullying relationship, that those most at risk of suicide were the young people being bullied. While this is inconsistent with the research of Kaltiala-Heino et al. (1999), who found that bullies were more at risk of suicide, this is possibly due to inadequate coping skills, or factors pertinent to New Zealand. Petrie (2012) claims that New Zealand has one of the highest rates of bulling within the developed world. The higher rates of bullying are possibly influenced by factors related to New Zealand's unique multi-cultural society (Ward & Masgoret, 2008) or differences in the socio-economic status within New Zealand (Kljakovic et al.,

2015). Of significance, Kljakovic et al. (2015) identified that Māori were victim to more cyber-bullying that New Zealand Europeans or 'other' ethnicities.

Some participants identified that young people who do not possess the necessary skills to manage the dissolution of an intimate relationship can perceive the future in a negative manner, which can influence suicide. Given previous research (such as Beautrais, 2001) this was an expected result. Of significance was that participants identified how the loss of a first relationship, or being in a relationship that was sporadic, could have a negative impact. This is similar to research by Sprecher, Felmlee, Metts, Fehr, and Vanni (1998) who found that the level of commitment a young person had in their relationship was related to their distress in the period immediately following the break-up. In addition, high distress levels are due to relatively poor coping skills during a crisis (Mikulincer, Florian, & Weller, 1993).

In general, participants believed that a young person's emotional state significantly influenced suicidality, particularly depressive disorders. While this is consistent with previous research which has identified a correlation between depressive disorders and suicide (such as Brent et al., 1993, & Fisher, 1999), some participants believed there was a causative relationship. Participant's reported their knowledge on this relationship had typically been acquired from the media. Given this, it is necessary to clarify the relationship between depressive disorders and suicide for the general public of New Zealand. If young people living in New Zealand believe that suicide results from depressive disorders this will limit those who do not have a depressive disorder in seeking support. Furthermore, participants identified that young people have limited coping skills and experience required for emotional regulation. There was a similarity with the themes identified by Roen et al. (2008), such as young people attempting suicide because they see it as a viable option and suicide being trivialised.

This is possibly attributable to the high rates of youth suicide within New Zealand, which appears to normalise the occurrence.

Within New Zealand males die from suicide at a higher rate than females. Participants were aware of this and discussed how the gender difference could be accounted for by the method of suicide, which is consistent with previous research (e.g. Beautrais, 2003). In addition, participants identified a stereotype of kiwi masculinity, and the need to be perceived as "macho", which was also identified in "Target Zero" (King, 2015). This provided a valuable insight to how gender stereotypes can influence suicidality, especially within New Zealand. The difference in rates of male and female suicide could be the result of socially constructed masculinities and femininities (Payne, Swami, & Stanistreet, 2008). Payne et al. (2008) acknowledge the importance of gender-sensitive policies as these may provide more success in addressing suicide, compared to policies which are gender-blind. A well designed campaign could challenge the kiwi masculinity stereotype that is engrained within New Zealand culture.

The majority of participants believed that alcohol and other drug use was a significant contributing factor to youth suicide, and that it impacted on a young person's ability to think clearly. Previous research has considered the impact of alcohol and drug use, and has identified this as a common risk factor (e.g. Shaffer et al., 1996). Within New Zealand, in the period 2011-2012, a high proportion (85%) of young people aged 18 to 24 years old consumed alcohol (Ministry of Health, 2013). Additionally, during the same period, the rate of young people aged 18 to 24 years old who were drinking at a hazardous level was 36% (Ministry of Health, 2013). It is likely that youth in New Zealand consider alcohol consumption to be a normal occurrence. Given the relationship between alcohol and other drug use and suicide it can be argued that the legal age for alcohol consumption should be raised. In addition, this highlighted that for

young people with alcohol and other drug use there is a possible shortage of support services, or they are reluctance to access these services. Furthermore, participants identified that suicide can be the result of a difficult circumstance. While participants did not identify specific circumstances they discussed that there are various events that occur, which can contribute to a suicide. This is consistent with previous research (such as Houston et al., 2001) that has considered the circumstances present before a suicide.

Several participants discussed support services available within New Zealand, such as phone lines. However, they identified, that for various reasons, many young people are reluctant to access these services. Previous research identified that young people rarely (2%) utilise dedicated youth phone lines, and are more likely (18%) to engage in web based chat with their peers (Gould, Monfakh, Lubell, Kleinman, & Parker, 2002). Participants identified that young people are hesitant to access these services due to fear of being judged or the belief that they need to "harden up". This is similar to research of Givens and Tija (2002) who identified that barriers for young people accessing support include: a lack of time, lack of confidentiality, stigma of seeking support, and the associated financial cost. In addition, participants discussed the New Zealand campaign on depressive disorders, fronted by Sir John Kirwan. They believed that a similar campaign, on youth suicide, will be beneficial for young people living in New Zealand. It is important this such a campaign provides information on accessing support when feeling suicidal without normalising suicide, as this would depict suicide as an acceptable option amongst young people (Cialdini, 2003).

Recommendations

This results from this research lead to a variety of recommendations. Firstly, New Zealand must address the gender stereotypes within society. Given how some young males within New Zealand are aware of, and adhere to, a kiwi masculinity stereotype, there may be a reluctance to express their emotions and access support when suicidal. The first step is to acknowledge that any person, regardless of their gender, can become distressed and suicidal, and require support, and that males do not need to adopt the traditional notion of being the stronger sex (Payne et al., 2008).

Secondly, the New Zealand educational curriculum needs to be adapted to provide students with information and support immediately after a suicide occurs within their community. The programme should be offered to students on, at least, an annual basis, with additional support if a school student dies from suicide. This is particularly important as Shilubane et al. (2014) reported that the participants in their study were pre-occupied with suicide, due to a lack of support offered after a peer had attempted or died from suicide. Through acknowledging suicide, students will gain a more thorough understanding; it is expected that they will be more likely to access support if they, or their peers, later require it. It is hoped that consistently providing this educational component to young New Zealanders will reduce their reluctance to access support.

Simultaneously, it would be useful to implement a nation-wide suicide prevention campaign, similar to the campaign on depressive disorders that is fronted by Sir John Kirwan. Careful consideration needs to be given to acquire the most appropriate spokesperson (or people). Ideally, this campaign would enable young people to acknowledge that they can seek help if they, or someone they know, is feeling

suicidal. If managed correctly, this campaign will empower young people to seek help when feeling suicidal, and importantly, will not glorify suicide.

Furthermore, there is a need for an additional framework that supports young people to manage the contextual factors, such as bullying, alcohol or other drug use, and intimate relationship break-ups, which impact on their daily lives. This can be established within schools and cover topics such as: distress tolerance, emotional regulation, and social skills, as previous research has identified that positive self-appraisals provide a source of resilience (Johnson, Gooding, Wood, & Tarrier, 2010). Ideally, these topics will be incorporated into the health curriculum, with guidance counsellors providing additional support to students. Furthermore, teachers need to be mindful of how their students are coping at school, to consider their social and emotional well-being as well as their academic well-being, and to encourage them to seek support if necessary. Additionally, there needs to be continued support for young people who are no longer at school. This would include advertising for support services at locations such as restrooms in shopping centres.

The majority of participants' knowledge on suicide resulted from the media. Therefore, it is necessary that the messages within the public domain are accurate, and that the media consider the purpose of their reporting. Most importantly, it is imperative that all media reports and interventions use the appropriate terminology, and refer to an individual who has 'died from suicide', rather than someone who 'committed suicide'. Lastly, it is important to acknowledge that there are many factors that influence youth suicide. To imply that suicide is caused by only one variable ignores the other factors that influence suicide (Sinyor et al., 2014), and may increase a young person's reluctance to seek support when feeling suicidal.

Limitations and Future Research

A limitation of this research is the lack of diversity within the sample. The majority of participants were female (84%) and 79% of the sample identified as solely New Zealand European or Pakeha. Given that New Zealand males die from suicide at a higher rate than females, and that Māori experience higher rates of suicide than non-Māori, it would be beneficial to conduct research with a sample that includes more males and is more diverse in terms of ethnicity. In addition, future samples that record participants' personal statistics, such as sexuality and alcohol and other drug use, would be useful, as these factors have, in previous research, been identified as relevant to suicide.

This research utilised focus groups; there are possible limitations with this approach. Focus groups are not as in depth as individual interviews, and participants may not express their honest opinions. Participants may have found it uncomfortable to discuss their views on suicide in the presence of others. In each focus group it is possible that participants were reluctant to discuss views that differed from other people, or they may have felt pressure to provide answers in accordance with the questions being asked.

Given that I had conducted a literature review prior to facilitating the focus groups I had an idea of the possible risk factors, and in some instances, asked participants what they thought of a particular risk factor (such as mental illness), when it was not voluntarily discussed, and this will have influenced the discussion. In addition, the small sample may not be representative of the population. Therefore, it would be worthwhile for future research to conduct focus groups with a larger sample in more towns and cities throughout New Zealand.

Conclusion

In conclusion, participants on this research identified a variety of factors which they believe influence suicide. Participants were concerned about the increase in cyber-bullying and how this could impact on suicide rates within New Zealand. On the whole, participants expressed an interest in addressing, and reducing, the rate of suicide within New Zealand (such as the implementation of a televised suicide prevention campaign). While this research was conducted at an individual level the information gained can provide positive changes at a community level. In summary, similar to results of Roen et al. (2008) participants believe that suicide occurs because it is considered to be an option, and is normalised by society.

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Appendix A

Permission to Advertise

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Exploring young people's views on why New Zealand youth attempt or commit suicide

PERMISSION TO ADVERTISE FOR PARTICIPANTS

Hi, my name is Casey Williams. I am undertaking research to complete a Masters in Psychology at Massey University. This project is being supervised by Dr Tatiana Tairi and Prof Antonia Lyons, from the Wellington School of Psychology at Massey University.

The aim of this research is to gain insight and understanding into youth suicide within New Zealand. This research will explore why young people living in New Zealand think their peers attempt or commit suicide. Participants must be between the age of 16 and 24 years and be fluent in English.

I am aware that many young people, who could be potential participants, visit Evolve, and they may be interested in participating in this research. Therefore, I would like to ask for permission to place an advertisement at Evolve to recruit participants.

Please feel free to contact me, or one of my supervisors, if you have any questions.

Casey Williams 027 236 8474 caseywilliams500@gmail.com

Dr Tatiana Tairi 04 801 5799 (extension 63606) t.tairi@massey.ac.nz

Prof Antonia Lyons 04 801 5799 (extension 63604) a.lyons@massey.ac.nz

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/26. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.

Appendix B

Advertisement

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

RESEARCH PARTICIPANTS WANTED!

Share your thoughts on youth suicide within NZ

Are you

- Aged 16 to 24 years?
- Fluent in English?
- Willing to share your views on youth suicide within New Zealand?
- Able to attend a focus group in the Wellington area?
- Willing to have the focus group recorded?

About the focus group

- It will be held at a time and location that is convenient for you
- It will last approximately 60 minutes
- There will be snacks and non-alcoholic drinks
- All information will be kept confidential
- You will receive a koha of a $20 voucher for The Warehouse to say thanks for your time

If you have had a recent experience with suicide, because we do not wish to cause any additional distress, we ask that you do not participate and we can instead refer you to a supportive agency.

Researcher

Casey Williams 027 236 8474 call or text or caseywilliams500@gmail.com

Research Supervisors

Dr Tatiana Tairi 04 801 5799 extension 63606 or t.tairi@massey.ac.nz

Prof Antonia Lyons 04 801 5799 extension 63604 or a.lyons@massey.ac.nz

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/26. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.

Appendix C

Information Sheet

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Exploring young people's views on why New Zealand youth attempt or commit suicide

INFORMATION SHEET

Who is conducting the research?

Hi, my name is Casey Williams. I am undertaking this research to complete a Masters in Psychology at Massey University. This project is being supervised by Dr Tatiana Tairi and Prof Antonia Lyons, from the Wellington School of Psychology at Massey University.

What is the research about?

- The aim of this research is to gain insight and understanding into youth suicide within New Zealand.
- This research will explore why young people living in New Zealand think their peers attempt or commit suicide.
- You are invited to take part in this research. Participation is voluntary and all personal information will be kept confidential.

Who can take part?

- Participants must be between the age of 16 and 24 years and be fluent in English.

What will happen in the study?

- You will take part in a focus group, which is a group discussion. Each focus group will have four to five participants and last for approximately 60 minutes.
- During the focus group you will discuss your views on youth suicide within New Zealand.
- The focus group will be video and audio recorded, and later transcribed.
- You, and any people referred to, will be given a pseudonym, which you are welcome to choose. Any other identifying information will be omitted or changed in the transcript.
- You will be provided with snacks and non-alcoholic drinks during the focus group.
- As an appreciation of your time you will be given a $20 voucher for The Warehouse.
- After the data has been analysed you will be provided with a summary of the project findings.

Where will the research take place?

- Focus groups will be held either in rooms at the Massey University Wellington campus, or somewhere mutually convenient, and on a day and time that is mutually agreeable to all participants.

What will happen to the information collected?

- The recordings from the focus group will be transcribed into text by the researcher. The recordings, transcriptions and any associated notes will be used solely for the purposes of the research project.
- Recordings and transcriptions will be stored securely on a password protected computer, and only the researcher and supervisors will have access to the data.
- Once the research is completed, the data collected will be securely stored for five years, at which time it will be destroyed

What are my rights?

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question
- withdraw from the study (during the focus group session)
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- be given access to a summary of the project findings when it is concluded
- ask for the recorder to be turned off at any time during the interview

Project Contacts

- Casey Williams 027 236 8474 caseywilliams500@gmail.com
- Tatiana Tairi 04 801 5799 (extension 63606) t.tairi@massey.ac.nz
- Antonia Lyons 04 801 5799 (extension 63604) a.lyons@massey.ac.nz
- Please make contact with anyone in the research team if you have any questions.

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/26. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.

Te Kunenga ki Pūrehuroa

Massey University, School of Psychology - Te Kura Hinengaro Tangata
PO Box 756, Wellington 6140, New Zealand T +64 4 801 5799 F +64 4 801 2796 www.massey.ac.nz

Appendix D

Consent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Exploring young people's views on why New Zealand youth attempt or commit suicide

FOCUS GROUP PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree not to disclose anything discussed in the Focus Group.

I agree to respect the views and opinions of other participants.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: …….. Date: …….

Full Name – printed ……..

Please provide the name and contact number for a support person, who we can contact if your participation causes any emotional distress.

…….

Te Kunenga ki Pūrehuroa

Massey University, School of Psychology - Te Kura Hinengaro Tangata
PO Box 756, Wellington 6140, New Zealand T +64 4 801 5799 F +64 4 801 2796 www.massey.ac.nz

Appendix E

Interview Schedule

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
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TE KURA PŪKENGA TANGATA

Exploring young people's views on why New Zealand youth attempt or commit suicide

Interview questions and prompts schedule for focus groups

Introductions

Starting with the researcher, each participant will introduce themselves, including their first name, age, where they come from and what ethnic group they identify with.

Participants will be reminded of confidentiality and each will be asked to choose a pseudonym. Participants will be reminded that they can ask for either the video or audio recorder to be switched off at any time, and have the right to withdraw without question or penalty up until the end of the discussion.

The research topic will then be introduced by the researcher and reminded that questions about the research process are welcome anytime throughout the discussion.

Youth Suicide

Can you tell me what you know about youth suicide in New Zealand?

Where do you get information about youth suicide? (such as media, personal experiences, school?)

Have you discussed youth suicide with your friends/peers?

Can you tell me about your discussions?

Can you tell me your thoughts about why young people might consider suicide?

Why do you think New Zealand youth attempt suicide?

Why do you think New Zealand youth commit suicide?

What are some situations that you think youth are faced with when they make this decision? (e.g. bullying, alcohol or drug use, relationship problems, mental illness, school or family stressors, abuse)

Why do you think others, possibly in a similar situation, do not attempt or commit suicide?

Depending on what is mentioned, there could be follow up questions such as:

Can you tell me your views on why people of that age (e.g. 16 year olds) attempt or commit suicide?

Why do you think it is more prevalent in males or females?

Why do you think more Māori attempt or commit suicide?

Appendix F

Support Organisations

SUPPORT AND INFORMATION GROUPS

Thank you for taking the time to participate in this research project. Your time, effort, and opinions are sincerely appreciated. If you have any further questions regarding this research project please do not hesitate to contact me via caseywilliams500@gmail.com or 027 236 8474. On completion of the project you will be given the opportunity to view a summary of the research findings.

If the discussion today has made you feel upset or prompted you to seek further information about suicide, please consider contacting one of the following groups.

Suicide Prevention

Website www.spinz.org.nz

YouthLine

A 24 hour confidential service

Phone 0800 376 633

Text 234 (free)

Email talk@youthline.co.nz

Website www.urge.co.nz

Lifeline

A 24 hour counselling service

Phone 0800 543 354

Website www.lifeline.co.nz

What's Up

A phone counselling service

Phone 0800 942 878

Website www.what'sup.co.nz

Police No Bully Helpline

A 24 hour information line

Phone 0800 662 855

Outline NZ

For help with gender issues

Phone 0800 688 546

Website www.gaynz.com

Gay and Lesbian Line

Phone 0800 802 437

Alcohol and Drug Helpline

Phone 0800 787 797

Gambling Hotline

Phone 0800 654 655

Depression Helpline

Phone 0800 111 757

Text 5626

Website www.thelowdown.co.nz

Appendix G

Ethical Approval

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA

22 July 2015

Casey Williams

Dear Casey

Re: HEC: Southern A Application – 15/26
Exploring young people's views on why New Zealand youth attempt or commit suicide

Thank you for your letter dated 21 July 2015.

On behalf of the Massey University Human Ethics Committee: Southern A I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Mr Jeremy Hubbard, Chair
Massey University Human Ethics Committee: Southern A

cc Dr Tatiana Tairi
School of Psychology
WELLINGTON

Prof Antonia Lyons
School of Psychology
WELLINGTON

Prof James Liu, HoS
School of Psychology
ALBANY

Massey University Human Ethics Committee
Accredited by the Health Research Council
Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11222, Palmerston North 4442, New Zealand **T** 06 3505573; 06 3505575 **F** 06 350 5622
E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz **www.massey.ac.nz**

Appendix H

Codes

Alcohol and drugs

Acceptance

Accidental

Accidents

Anti-depressants

Argument

Ashamed

Attention seeking

Awareness

Body weight

Brain

Bullying

Bullying – cyber bullying, mental health

Can’t escape

Can’t talk about it

Circumstances

Cognitions

Common

Confidence

Cool

Coping skills

Copycat

Culture

Cynical

Depressed

Depression

Different

Difficulties

Disguise (sexuality)

Domestic abuse

Education

Emotions

Environment – childhood, family, parents, pre-disposed, school

Ethnicity

Expectations

Facebook

Family

Finances

Freaky

Gay

Gender – rates, school, stereotypes

Generational

Genetic

Grief

Guilt

Guilt/regret

Hormones

Housing

Identity

Insecure

Isolated

John Kirwan

Judgement

Knowledge – network, personal

Labelled

Local community

Low decile

Media

Method – access

Mental health – eating disorders, inpatient

No one understands

Normalise

Not normal

Option

Other

Personality

Perspective

Physical abuse

Poverty

Pressure to fit in

Problem

Rates – ethnicity, gender, transgender/transsexual

Reasons

Relationships – family

Religion

Resilience

Risk

Run away

School – experience, hierarchies

School culture

Self-harm

Selfish

Sexual abuse

Society

Stereotype

Stigma

Stress – family, school

Suicide pact

Support – access, gender, mental health, parents

Taboo

Tough

Trans-gender

Understanding

Unexpected

Unloved

Unsuccessful

Vulnerable age

Wow